

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042341</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Rosewood Care Ctr Northbrook</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2001</u> to <u>6/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>4101 Lake Cook Road</u> <u>Northbrook</u> <u>60062</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(847) 562-1770</u> Fax # () _____		Paid Preparer (Signed) <u>Accountant's Compilation Report Attached</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
IDPA ID Number: <u>431660454001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>6/22/98</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>			

SEE ACCOUNTANT'S COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Ctr Northbrook# 0042341 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>147</u>	Skilled (SNF)	<u>147</u>	<u>53,655</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>147</u>	TOTALS	<u>147</u>	<u>53,655</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,569</u>	<u>2,569</u>	8
9	SNF/PED					9
10	ICF	<u>16,474</u>	<u>7,696</u>		<u>24,170</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,474</u>	<u>7,696</u>	<u>2,569</u>	<u>26,739</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 49.84%D. How many bed-hold days during this year were paid by Public Aid?
97 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 6/22/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/22/98 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 72 and days of care provided 2,569Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2002 Fiscal Year: 6/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Rosewood Care Ctr Northbrook

0042341

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	233,158	27,775	5,663	266,596		266,596		266,596		1
2	Food Purchase		158,210		158,210		158,210	(2,414)	155,796		2
3	Housekeeping	168,651	26,521		195,172		195,172		195,172		3
4	Laundry	47,518	13,855		61,373		61,373		61,373		4
5	Heat and Other Utilities			127,342	127,342		127,342	477	127,819		5
6	Maintenance	19,433	3,550	83,110	106,093		106,093	20,021	126,114		6
7	Other (specify):* Sanitation Services			11,424	11,424		11,424		11,424		7
8	TOTAL General Services	468,760	229,911	227,539	926,210		926,210	18,084	944,294		8
	B. Health Care and Programs										
9	Medical Director			3,450	3,450		3,450		3,450		9
10	Nursing and Medical Records	2,016,843	143,536	108,580	2,268,959		2,268,959		2,268,959		10
10a	Therapy	87,638	1,630	158,693	247,961		247,961	18,412	266,373		10a
11	Activities	53,319	9,398	2,358	65,075		65,075		65,075		11
12	Social Services	42,827		2,921	45,748		45,748		45,748		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,200,627	154,564	276,002	2,631,193		2,631,193	18,412	2,649,605		16
	C. General Administration										
17	Administrative			161,700	161,700		161,700	10,724	172,424		17
18	Directors Fees										18
19	Professional Services			7,738	7,738		7,738	42,004	49,742		19
20	Dues, Fees, Subscriptions & Promotions			40,009	40,009		40,009	(10,852)	29,157		20
21	Clerical & General Office Expenses	162,846	27,210	32,856	222,912		222,912	189,393	412,305		21
22	Employee Benefits & Payroll Taxes			312,587	312,587		312,587	36,704	349,291		22
23	Inservice Training & Education										23
24	Travel and Seminar			20	20		20		20		24
25	Other Admin. Staff Transportation			4,335	4,335		4,335	21,060	25,395		25
26	Insurance-Prop.Liab.Malpractice			45,601	45,601		45,601	7,398	52,999		26
27	Other (specify):*										27
28	TOTAL General Administration	162,846	27,210	604,846	794,902		794,902	296,431	1,091,333		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,832,233	411,685	1,108,387	4,352,305		4,352,305	332,927	4,685,232		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Rosewood Care Ctr Northbrook

#0042341

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					597	597	376,456	377,053			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			451,909	451,909		451,909	173,510	625,419			32
33	Real Estate Taxes			211,081	211,081		211,081		211,081			33
34	Rent-Facility & Grounds			1,253,039	1,253,039		1,253,039	(1,238,015)	15,024			34
35	Rent-Equipment & Vehicles			2,767	2,767		2,767		2,767			35
36	Other (specify):*			597	597	(597)						36
37	TOTAL Ownership			1,919,393	1,919,393		1,919,393	(688,049)	1,231,344			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,013	4,839	66,852		66,852	(469)	66,383			39
40	Barber and Beauty Shops			2,867	2,867		2,867		2,867			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,484	80,484		80,484		80,484			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		62,013	88,190	150,203		150,203	(469)	149,734			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,832,233	473,698	3,115,970	6,421,901		6,421,901	(355,591)	6,066,310			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Ctr Northbrook**# **0042341**Report Period Beginning: **7/1/2001**Ending: **6/30/2002****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(2,189)	2		4
5 Telephone, TV & Radio in Resident Rooms	(1,890)	21		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(3,830)	32		10
11 Discounts, Allowances, Rebates & Refunds	(469)	39		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(225)	2		13
14 Non-Care Related Interest	(451,909)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(3,000)	20		17
18 Fines and Penalties				18
19 Entertainment	(90)	19		19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(4,721)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(3,819)	20		28
29 Other-Attach Schedule Marketing Salary	(61,614)	21		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (533,756)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule	178,165	Var	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 178,165		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (355,591)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr Northbrook

ID# 0042341

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary	\$ (61,614)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(61,614)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,414)	0	0	0	0	0	0	0	0	0	0	(2,414)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	477	0	0	0	0	0	0	0	0	477	5
6	Maintenance	0	0	20,021	0	0	0	0	0	0	0	0	20,021	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,414)	0	20,498	0	0	0	0	0	0	0	0	18,084	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	18,412	0	0	0	0	0	0	0	0	0	18,412	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	18,412	0	0	0	0	0	0	0	0	0	18,412	16
	C. General Administration													
17	Administrative	0	(161,700)	172,424	0	0	0	0	0	0	0	0	10,724	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(90)	0	42,094	0	0	0	0	0	0	0	0	42,004	19
20	Fees, Subscriptions & Promotions	(11,540)	0	688	0	0	0	0	0	0	0	0	(10,852)	20
21	Clerical & General Office Expenses	(63,504)	0	252,897	0	0	0	0	0	0	0	0	189,393	21
22	Employee Benefits & Payroll Taxes	0	0	36,704	0	0	0	0	0	0	0	0	36,704	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	21,060	0	0	0	0	0	0	0	0	21,060	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,398	0	0	0	0	0	0	0	0	7,398	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(75,134)	(161,700)	533,265	0	0	0	0	0	0	0	0	296,431	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,548)	(143,288)	553,763	0	0	0	0	0	0	0	0	332,927	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Rosewood Care Ctr Northbrook# 0042341

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 161,700	HSM Management Services, Inc.	100.00%	\$	\$ (161,700)	1
2	V							2
3	V	10a Therapy	158,693	Rosewood Therapy Services, Inc.	0.00%	177,105	18,412	3
4	V							4
5	V	34 Rent	1,253,039	Northbrook Real Estate, Inc.	0.00%		(1,253,039)	5
6	V	30 Depreciation		Northbrook Real Estate, Inc.		348,418	348,418	6
7	V	32 Interest		Northbrook Real Estate, Inc.		604,170	604,170	7
8	V	32 Amortization - Loan Fee		Northbrook Real Estate, Inc.		25,079	25,079	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,573,432			\$ 1,154,772	\$ * (418,660)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook# 0042341Report Period Beginning: 7/1/2001Ending: 6/30/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 172,424	\$ 172,424
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	252,897	252,897
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	36,704	36,704
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	21,060	21,060
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	28,038	28,038
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	15,024	15,024
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	42,094	42,094
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	7,398	7,398
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	20,021	20,021
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	477	477
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	688	688
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 596,825	\$ * 596,825

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	813,422	3	7.21%	Salary	\$ 63,158	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	579,735	3	7.21%	Salary	45,013	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 108,171		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/2001 Ending: 7/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Salaries - Officers	Total Cost	78,691,907	17	\$ 1,501,328	\$ 1,501,328	5,669,764	\$ 108,171	1
2	21 Salaries - Others	Total Cost	78,691,907	17	2,971,209	2,971,209	5,669,764	214,076	2
3	22 Payroll Taxes	Total Cost	78,691,907	17	275,345		5,669,764	19,839	3
4	22 Employee Benefits	Total Cost	78,691,907	17	147,178		5,669,764	10,604	4
5	25 Travel	Total Cost	78,691,907	17	280,565		5,669,764	20,215	5
6	30 Depreciation	Total Cost	78,691,907	17	359,545		5,669,764	25,905	6
7	34 Building Rent	Total Cost	78,691,907	17	208,527		5,669,764	15,024	7
8	19 Professional Services	Total Cost	78,691,907	17	584,225		5,669,764	42,094	8
9	21 Telephone	Total Cost	78,691,907	17	234,306		5,669,764	16,882	9
10	26 Insurance	Total Cost	78,691,907	17	102,679		5,669,764	7,398	10
11	21 Taxes, Licenses, Office Supplies	Total Cost	78,691,907	17	304,491		5,669,764	21,939	11
12	6 Maintenance	Total Cost	78,691,907	17	276,408		5,669,764	19,915	12
13	5 Heat & Other Utilities	Total Cost	78,691,907	17	6,619		5,669,764	477	13
14	20 Dues & Subscriptions	Total Cost	78,691,907	17	9,548		5,669,764	688	14
15	17 Direct - Admin	Direct Cost	1	1	64,253	64,253	1	64,253	15
16	17 Direct - Admin	Direct Cost	16	16	924,466	924,466	0	0	16
17	22 Direct - Payroll Taxes	Direct Cost	1	1	6,261		1	6,261	17
18	22 Direct - Payroll Taxes	Direct Cost	16	16	72,755		0	0	18
19	30 Direct - Depreciation	Direct Cost	1	1	2,133		1	2,133	19
20	30 Direct - Depreciation	Direct Cost	16	16	14,176		0	0	20
21	25 Direct - Travel	Direct Cost	1	1	845		1	845	21
22	25 Direct - Travel	Direct Cost	16	16	14,982		0	0	22
23	6 Direct - Maintenance	Direct Cost	1	1	106		1	106	23
24	6 Direct - Maintenance	Direct Cost	16	16	3,120		0	0	24
25	TOTALS				\$ 8,365,070	\$ 5,461,256		\$ 596,825	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Firstar Bank		X	Mortgage	Varies	6/98	\$	\$	10,636,677		Prm + 1/2	\$	639,532	1
2	Less: Related Party Interest Income Offset												(35,362)	2
3	Amortization of Loan Fees												25,079	3
4	Interest Income												(3,830)	4
5														5
	Working Capital													
6														6
7														7
8														8
9	TOTAL Facility Related						\$	\$	10,636,677			\$	625,419	9
	B. Non-Facility Related*													
10														10
11														11
12														12
13														13
14	TOTAL Non-Facility Related						\$	\$				\$		14
15	TOTALS (line 9+line14)						\$	\$	10,636,677			\$	625,419	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Rosewood Care Ctr Northbrook**# **0042341** Report Period Beginning: **7/1/2001** Ending: **6/30/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2001 report.		\$	130,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	133,258	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,258	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	207,823	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	211,081	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	33,831	8	
	1998	84,000	9	
	1999	87,636	10	
	2000	118,050	11	
	2001	176,848	12	
2000 Payment \$74,232				
2001 Payment \$59,025				
Accrual = Remainder of 2001 tax bill owed (117,823) + 1/2 of 2002 estimated tax (90,000)				
				FOR OHF USE ONLY
13 FROM R. E. TAX STATEMENT FOR 2001 \$				13
14 PLUS APPEAL COST FROM LINE 5 \$				14
15 LESS REFUND FROM LINE 6 \$				15
16 AMOUNT TO USE FOR RATE CALCULATION \$				16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042341

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-06-101-006-0000</u>	<u>4105 Kingston Rd, Northbrook</u>	\$ <u>83,606.89</u>	\$ <u>83,606.89</u>
2. <u>04-06-101-007-0000</u>	<u>4065 Kingston Rd, Northbrook</u>	\$ <u>93,241.41</u>	\$ <u>93,241.41</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>176,848.30</u></u>	\$ <u><u>176,848.30</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:
63,834

B. General Construction Type:

Exterior
Brick Veneer

Frame
Steel

Number of Stories
2

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	6.6 Acres	1998	\$ 1,313,000	1
2					2
3	TOTALS	#VALUE!		\$ 1,313,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	147			1998	\$ 8,660,744	\$	25-40	\$ 236,043	\$ 236,043	\$ 945,230	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements - Management Company:										
10	Office Construction/Improvements			1995	552		5			552	10
11	Office Design			1995	50		5			50	11
12	Office Shelving			1996	118		4			118	12
13	Office Expansion			1996	521		4			521	13
14	Office Expansion			1997	1,394		3			1,394	14
15	Office Expansion			1998	786		3	57	57	786	15
16	Office Addition			1999	388		3	130	130	388	16
17	Door Locks			1999	194		3	65	65	167	17
18											
19	Facility Leaseholds:										
20	Computer Cabling			2001	3,230	460	7	460		691	20
21	TV Lounge Carpet			2002	2,870	137	7	137		137	21
22											
23											
24											
25	Fence Installation			1998	1,900		7	271	271	1,179	25
26	Patient Monitoring System			1998	54,214		7	7,745	7,745	29,753	26
27	Signs			1998	21,364		7	3,051	3,051	11,721	27
28	Cabinets			1998	11,679		7	1,668	1,668	6,409	28
29	Drains			1998	3,833		7	548	548	2,104	29
30	Stone Pavers			1998	9,661		7	1,380	1,380	5,302	30
31	Handicap Rails			1998	23,313		7	3,330	3,330	12,793	31
32	Sprinkler Water Pumps			1998	37,340		7	5,334	5,334	20,492	32
33	Generator			1998	74,806		7	10,687	10,687	41,057	33
34	Security Monitoring System			1998	22,221		7	3,174	3,174	12,194	34
35	Paging System			1998	46,099		7	6,586	6,586	25,301	35
36	Plumbing for Lawn Irrigation			1998	12,549		7	1,793	1,793	6,888	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,989,826	\$ 597		\$ 282,459	\$ 281,862	\$ 1,125,227	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 573,573	\$	\$ 84,353	\$ 84,353	5-7 Yrs	\$ 333,755	71
72	Current Year Purchases	12,452		1,553	1,553	5-7 Yrs	1,553	72
73	Fully Depreciated Assets	28,290					28,290	73
74								74
75	TOTALS	\$ 614,315	\$	\$ 85,906	\$ 85,906		\$ 363,598	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 35,432	\$	\$ 8,688	\$ 8,688	4 Yrs	\$ 23,778	76
77										77
78										78
79										79
80	TOTALS			\$ 35,432	\$	\$ 8,688	\$ 8,688		\$ 23,778	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,952,573	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 377,053	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 376,456	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,512,603	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

16. Rental Amount for movable equipment: \$ Description:

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

12.	<u> </u>	<u>/2003</u>	\$ <u> </u>
13.	<u> </u>	<u>/2004</u>	\$ <u> </u>
14.	<u> </u>	<u>/2005</u>	\$ <u> </u>

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	\$	\$		\$	
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	5,251	\$ 103,261	\$	5,251	\$ 103,261	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		473	4,355		473	4,355	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		8,382	69,489	1,630	8,382	71,119	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				49,926		49,926	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12	Ambulance, X-Ray, Lab & Enteral Other (specify):									12
13	Supplies	39-8					16,457		16,457	13
14	TOTAL			\$	14,106	\$ 177,105	\$ 68,013	14,106	\$ 245,118	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 290,172	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,243,924		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,534,096	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,100		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(829)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,271	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,539,367	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 230,998	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	8,871,444		29
30	Accrued Salaries Payable	229,963		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,599		31
32	Accrued Real Estate Taxes(Sch.IX-B)	207,823		32
33	Accrued Interest Payable	307,321		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,869,148	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,869,148	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,329,781)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,539,367	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,307,423)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,307,423)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,022,358)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,022,358)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (8,329,781)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,421,757	1
2	Discounts and Allowances for all Levels	(632,379)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,789,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	591,791	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 591,791	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,420	13
14	Non-Patient Meals	2,189	14
15	Telephone, Television and Radio	1,890	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,499	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,830	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,830	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	4,045	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,045	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,399,543	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	926,210	31
32	Health Care	2,631,193	32
33	General Administration	794,902	33
	B. Capital Expense		
34	Ownership	1,919,393	34
	C. Ancillary Expense		
35	Special Cost Centers	69,719	35
36	Provider Participation Fee	80,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,421,901	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,022,358)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,022,358)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Rosewood Care Ctr Northbrook**# **0042341**Report Period Beginning: **7/1/2001**Ending: **6/30/2002****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,535	1,596	\$ 48,911	\$ 30.65	1
2	Assistant Director of Nursing	1,998	2,076	56,868	27.39	2
3	Registered Nurses	31,861	33,114	931,402	28.13	3
4	Licensed Practical Nurses	2,980	3,097	61,509	19.86	4
5	Nurse Aides & Orderlies	64,346	66,877	867,029	12.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,537	4,715	87,638	18.59	8
9	Activity Director					9
10	Activity Assistants	4,559	4,738	53,319	11.25	10
11	Social Service Workers	2,591	2,693	42,827	15.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,546	22,393	233,158	10.41	15
16	Dishwashers					16
17	Maintenance Workers	1,627	1,692	19,433	11.49	17
18	Housekeepers	19,035	19,784	168,651	8.52	18
19	Laundry	5,464	5,679	47,517	8.37	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,255	11,697	162,846	13.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,402	3,536	51,125	14.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,736	183,687	\$ 2,832,233 *	\$ 15.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	235	\$ 5,663	1-3	35
36	Medical Director	Contract	3,450	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	85	2,358	11-3	44
45	Social Service Consultant	105	2,921	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	425	\$ 14,392		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,502	\$ 82,351	10-3	50
51	Licensed Practical Nurses	61	2,378	10-3	51
52	Nurse Aides	1,111	23,751	10-3	52
53	TOTAL (lines 50 - 52)	2,674	\$ 108,480		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries						
Name	Function	% Ownership	Amount	Description	Amount	F. Dues, Fees, Subscriptions and Promotions Description Amount
J. Stare	Administrator	0.00%	\$ 49,253	Workers' Compensation Insurance	\$ 62,949	IDPH License Fee \$
Anderson	Administrator	0.00%	15,000	Unemployment Compensation Insurance		Advertising: Employee Recruitment 14,816
				FICA Taxes	216,079	Health Care Worker Background Check (Indicate # of checks performed 50) 742
				Employee Health Insurance	3,381	Misc. Dues/Subscriptions 12,911
				Employee Meals		Promotional Advertising 8,540
				Illinois Municipal Retirement Fund (IMRF)*		Management Company Allocations 688
				Employee Physicals	457	
				Employee Relations	1,729	
				Employee Uniforms	505	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,253	Management Company Allocations	36,704	
B. Administrative - Other				State Unemployment Tax	17,677	
				Federal Unemployment Tax	9,318	Less: Public Relations Expense (2,425)
Description			Amount	Tuition Reimbursement	492	Non-allowable advertising (2,296)
Management Fees			\$ 161,700			Yellow page advertising (3,819)
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 349,291	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 161,700	Description Line # Amount		Description Amount
C. Professional Services	Type		Amount	Section Not Applicable		Out-of-State Travel \$
Vendor/Payee C.J. Schlosser & Company	Accountant/Consultant		\$ 7,738			In-State Travel
						Seminar Expense 20
						Entertainment Expense (agree to Sch. V,
						TOTAL (agree to Sch. V, line 24, col. 8) \$ 20
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 7,738	TOTAL	\$	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook

STATE OF ILLINOIS

0042341

Report Period Beginning: 7/1/2001

Page 23

Ending: 6/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69,894 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 80,484
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,189
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: C.J. Schlosser & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not finished.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER OF NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2002

RELATED NURSING HOME:

ROSEWOOD CARE CENTER OF ALTON
ROSEWOOD CARE CENTER OF EAST PEORIA
ROSEWOOD CARE CENTER OF JOLIET
ROSEWOOD CARE CENTER OF ELGIN
ROSEWOOD CARE CENTER OF GALESBURG
ROSEWOOD CARE CENTER OF INVERNESS
ROSEWOOD CARE CENTER OF MOLINE
ROSEWOOD CARE CENTER OF EDWARDSVILLE
ROSEWOOD CARE CENTER OF PEORIA
ROSEWOOD CARE CENTER OF ROCKFORD
ROSEWOOD CARE CENTER OF ST. CHARLES
ROSEWOOD CARE CENTER OF ST. LOUIS
ROSEWOOD CARE CENTER OF SWANSEA

CITY:

ALTON, IL
EAST PEORIA, IL
JOLIET, IL
ELGIN, IL
GALESBURG, IL
INVERNESS, IL
MOLINE, IL
EDWARDSVILLE, IL
PEORIA, IL
ROCKFORD, IL
ST. CHARLES, IL
ST. LOUIS, MO
SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

HSM MANAGEMENT SERVICES, INC.
NORTHBROOK REAL ESTATE, LLC
HSM DEVELOPMENT, INC.
RCC HOLDING COMPANY
ROSEWOOD HOME HEALTH
ROSEWOOD THERAPY SERVICES

TYPE OF BUSINESS:

MANAGEMENT CO.
REAL ESTATE LSG.
DEVELOPMENT CO.
HOLDING COMPANY
HOME HEALTH CO.
THERAPY COMPANY

ROSEWOOD CARE CENTER OF NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2002

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	\$4,335
	4,335

ROSEWOOD CARE CENTER INC. OF NORTHBROOK
RECLASSIFICATIONS
06/30/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
OTHER	36	(597)
DEPRECIATION	30	597
TO RECLASS DEPRECIATION EXPENSE DUE TO PROTECTED CELL		